

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0037960</div> <div>Facility Name: COLUMBUS PARK NRSG REHAB CTR</div> <div>Address: 901 SOUTH AUSTIN CHICAGO 60644</div> <div>County: COOK</div> <div>Telephone Number: (773) 287-5959 Fax # (773) 287-7909</div> <div>IDPA ID Number: 363801333001</div> <div>Date of Initial License for Current Owners: 01/01/92</div> <div>Type of Ownership:</div> <div><div><div><div>VOLUNTARY,NON-PROFIT</div><div><div>Charitable Corp.</div><div>Trust</div></div><div>IRS Exemption Code</div></div><div><div>X</div><div>PROPRIETARY</div><div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>X"Sub-S" Corp.</div><div>Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div><div>State</div><div>County</div><div>Other</div></div></div></div><div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div><div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) CARY C. BUXBAUM, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax#(847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div></div>
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Facility Name & ID Number

COLUMBUS PARK NRSRG REHAB CTR

#

0037960

Report Period Beginning:

01/01/01

Ending:

12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,420	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	13,502	270	2,376	16,148	8
9	SNF/PED					9
10	ICF	54,007	1,079		55,086	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,509	1,349	2,376	71,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

90.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 1/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 19 and days of care provided 1055

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	209,102	27,425	35,832	272,359		272,359	(21,856)	250,503		1
2	Food Purchase		307,180		307,180	(28,470)	278,710	(58)	278,652		2
3	Housekeeping	163,620	27,078		190,698		190,698	721	191,419		3
4	Laundry	76,045	32,391		108,436		108,436		108,436		4
5	Heat and Other Utilities			170,349	170,349		170,349	2,305	172,654		5
6	Maintenance	38,047		161,679	199,726		199,726	(36,520)	163,206		6
7	Other (specify):*							8,585	8,585		7
8	TOTAL General Services	486,814	394,074	367,860	1,248,748	(28,470)	1,220,278	(46,823)	1,173,455		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,745,735	92,841	311,547	2,150,123		2,150,123	(27,248)	2,122,875		10
10a	Therapy	127,498		6,434	133,932		133,932		133,932		10a
11	Activities	90,087	8,836	4,265	103,188		103,188		103,188		11
12	Social Services	62,064		3,137	65,201		65,201		65,201		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							3,949	3,949		15
16	TOTAL Health Care and Programs	2,025,384	101,677	332,583	2,459,644		2,459,644	(23,299)	2,436,345		16
	C. General Administration										
17	Administrative	109,900		532,440	642,340		642,340	(353,911)	288,429		17
18	Directors Fees										18
19	Professional Services			185,607	185,607	(10,256)	175,351	(95,636)	79,715		19
20	Dues, Fees, Subscriptions & Promotions			46,078	46,078		46,078	(18,263)	27,815		20
21	Clerical & General Office Expenses	115,458	31,662	100,216	247,336		247,336	(3,830)	243,506		21
22	Employee Benefits & Payroll Taxes			451,365	451,365	28,470	479,835	(7,382)	472,453		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,710	1,710		1,710	249	1,959		24
25	Other Admin. Staff Transportation			173	173		173	4,057	4,230		25
26	Insurance-Prop.Liab.Malpractice			85,088	85,088		85,088	1,200	86,288		26
27	Other (specify):*							32,439	32,439		27
28	TOTAL General Administration	225,358	31,662	1,402,677	1,659,697	18,214	1,677,911	(441,077)	1,236,834		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,737,556	527,413	2,103,120	5,368,089	(10,256)	5,357,833	(511,199)	4,846,634		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,675	57,675		57,675	35,693	93,368			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,001	43,001		43,001	4,504	47,505			32
33	Real Estate Taxes			142,657	142,657	10,256	152,913	4,882	157,795			33
34	Rent-Facility & Grounds			1,064,340	1,064,340		1,064,340	(10,602)	1,053,738			34
35	Rent-Equipment & Vehicles			5,687	5,687		5,687	8,296	13,983			35
36	Other (specify):*											36
37	TOTAL Ownership			1,313,360	1,313,360	10,256	1,323,616	42,773	1,366,389			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,754	64,929	124,683		124,683		124,683			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,754	183,189	242,943		242,943		242,943			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,737,556	587,167	3,599,669	6,924,392		6,924,392	(468,426)	6,455,966			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,828	30		9
10	Interest and Other Investment Income	(588)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(216)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,190)	21		24
25	Fund Raising, Advertising and Promotional	(7,863)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,708)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,554)	20		28
29	Other-Attach Schedule	(49,302)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,651)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(368,775)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (368,775)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (468,426)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0037960

Report Period Beginning:01/01/01

Ending:12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	Misc. Income - Lower Rental Income	\$ (9,000)	34 1
2	Misc. Income - Telephone Rental Income	(1,603)	34 2
3	Misc. Income - Jury Duty Income	(69)	10 3
4	Veteran Expenses	(5,616)	10 4
5	Trust fees	(150)	20 5
6	Collection Fees	(440)	21 6
7	Prisn Year Legal Fees	(92)	19 7
8	ICLTC - COPE	(3,764)	20 8
9	FY 2002 Seminar	(180)	24 9
10	Capitalized Repairs & Maintenance	(11,077)	6 10
11	Non-allowable Legal	(9,425)	19 11
12	Tickets	(7,382)	22 12
13			13
14			14
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR

0037960

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(21,856)							(21,856)	1
2	Food Purchase	(58)											(58)	2
3	Housekeeping			721									721	3
4	Laundry													4
5	Heat and Other Utilities			870	1,435								2,305	5
6	Maintenance	(11,077)		645	(12,399)	(13,689)							(36,520)	6
7	Other (specify):*				778	7,807							8,585	7
8	TOTAL General Services	(11,135)		2,236	(10,186)	(27,738)							(46,823)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,685)			(21,563)								(27,248)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,949								3,949	15
16	TOTAL Health Care and Programs	(5,685)			(17,614)								(23,299)	16
	C. General Administration													
17	Administrative			16,617	(67,062)	(308,393)		4,927					(353,911)	17
18	Directors Fees													18
19	Professional Services	(10,022)		(90,438)	(9,812)	14,617		19					(95,636)	19
20	Fees, Subscriptions & Promotions	(18,547)		84	188			12					(18,263)	20
21	Clerical & General Office Expenses	(64,338)		52,711	7,779			18					(3,830)	21
22	Employee Benefits & Payroll Taxes	(7,382)											(7,382)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(180)		121	308								249	24
25	Other Admin. Staff Transportation			682	3,375								4,057	25
26	Insurance-Prop.Liab.Malpractice			449	714			37					1,200	26
27	Other (specify):*			9,617	9,235	13,041		546					32,439	27
28	TOTAL General Administration	(100,469)		(10,157)	(55,275)	(280,735)		5,559					(441,077)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,289)		(7,921)	(83,075)	(308,473)		5,559					(511,199)	29

Summary B

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	28,828		2,671	4,194								35,693	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(588)		1,185	3,907								4,504	32
33	Real Estate Taxes			1,625	3,257								4,882	33
34	Rent-Facility & Grounds	(10,602)											(10,602)	34
35	Rent-Equipment & Vehicles			2,765	5,239			292					8,296	35
36	Other (specify):*													36
37	TOTAL Ownership	17,638		8,246	16,597			292					42,773	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(99,651)		325	(66,478)	(308,473)		5,851					(468,426)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 721	\$	721
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	870		870
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	645		645
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,617		16,617
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,888		1,888
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	84		84
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	52,711		52,711
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	121		121
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	682		682
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	449		449
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,617		9,617
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,671		2,671
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,185		1,185
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,625		1,625
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,765		2,765
30	V								30
31	V								31
32	V	19	ACCOUNT/BOOKKEEPING	92,326	PREFERRED BOOKKEEPING	100.00%			(92,326)
33	V	19	COMPUTER	5,184	PREFERRED BOOKKEEPING	100.00%	5,184		
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 97,510			\$ 97,835	\$ *	325

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,435	\$ 1,435	15
16	V	6	REPAIRS AND MAINT.	19,440	S.I.R. MANAGEMENT, INC.	100.00%	7,041	(12,399)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	778	778	17
18	V	10	NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	21,205	(21,563)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,949	3,949	19
20	V	17	ADMINISTRATIVE	75,816	S.I.R. MANAGEMENT, INC.	100.00%	8,754	(67,062)	20
21	V	19	PROFESSIONAL FEES	17,496	S.I.R. MANAGEMENT, INC.	100.00%	7,684	(9,812)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	188	188	22
23	V	21	CLERICAL & GENERAL	22,032	S.I.R. MANAGEMENT, INC.	100.00%	29,811	7,779	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	308	308	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,375	3,375	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	714	714	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,235	9,235	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,194	4,194	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,907	3,907	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,257	3,257	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,239	5,239	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 177,552			\$ 111,074	\$ * (66,478)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 22,032	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,198	\$ (15,834)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,166	1,166	16
17	V	17	ADMIN./LEGAL SALARIES	380,304	S.I.R. MANAGEMENT, INC.	100.00%	71,911	(308,393)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,617	14,617	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	13,041	13,041	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	39,924	S.I.R. MANAGEMENT, INC.	100.00%	26,235	(13,689)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	5,122	5,122	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	13,800	S.I.R. MANAGEMENT, INC.	100.00%	7,778	(6,022)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,519	1,519	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 456,060			\$ 147,587	\$ * (308,473)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 68,779	\$ 68,779	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	68,779	CCS EMPLOYEE BENEFIT GROUP	100.00%		(68,779)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 68,779			\$ 68,779	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	ECM OWNERS COUNCIL	100.00%	\$ 19	\$	19
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12		12
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	18		18
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	37		37
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	292		292
20	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%			(4,320)
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	9,247		9,247
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	546		546
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 4,320			\$ 10,171	\$ *	5,851

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NRSG REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	3.77%	see attached	.71	0.99%	SIR salary	\$ 1,743	17-7	1
2	Noah Wolff	Owner	Administrative	4.25%	see attached	0		Mgmt Fees	36,000	17-3	2
3	Leo Feigenbaum	Owner	Administrative	13.21%	see attached	1	1.52%	Mgmt Fees	36,000	17-3	3
4	Bryan Barrish	Owner	Administrative	14.38%	see attached	4.53	10.07%	SIR salary	18,891	17-7	4
5	Mike Giannini	Owner	Administrative	6.60%	see attached	4.53	10.07%	SIR, ECMOC	19,019	17-7	5
6	Arturo Rominiquit	Relative	Clerical		see attached	4.28	10.70%	Pref Book	2,421	21-7	6
7	Nenita Guzman	Owner	Dietary	1.89%	see attached	5.66	11.32%	SIR salary	6,198	1-7	7
8	Tom Winter	Owner	Administrative	0.94%	see attached	6.41	10.68%	Pref Book	16,617	17-7	8
9	Louise Bergthold	Owner	Administrative	4.25%	see attached	6.22	11.31%	SIR salary	20,881	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 157,770		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR# 0037960

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

PREFERRED BOOKEEPING SERVICES

Street Address

4100 WEST PRATT AVE.

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 674-5200

Fax Number

(847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	\$ 6,745	\$	92,326	\$ 721	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		92,326	870	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		92,326	645	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	92,326	16,617	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		92,326	1,888	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		92,326	84	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	92,326	52,711	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		92,326	121	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		92,326	682	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		92,326	449	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		92,326	9,617	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		92,326	2,671	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		92,326	1,185	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		92,326	1,625	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		92,326	2,765	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,184	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 866,833	\$ 587,636		\$ 97,835	25

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	\$ 12,680	\$ 71,234	71,234	\$ 1,435	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	71,234	7,041	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		71,234	778	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	71,234	21,205	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		71,234	3,949	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	71,234	8,754	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		71,234	7,684	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		71,234	188	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	71,234	29,811	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		71,234	308	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		71,234	3,375	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		71,234	714	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		71,234	9,235	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		71,234	4,194	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		71,234	3,907	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		71,234	3,257	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		71,234	5,239	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 981,450	\$ 522,555		\$ 111,074	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	\$ 54,767	\$ 54,767	71,234	\$ 6,198	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		71,234	1,166	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	71,234	71,911	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		71,234	14,617	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	\$ 115,229	\$	71,234	\$ 13,041	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	\$ 11,413	\$		\$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	39,924	26,235	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	\$ 28,377	\$	39,924	\$ 5,122	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	13,800	7,778	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		13,800	1,519	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,272,944	\$ 964,662		\$ 147,587	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address 4101 W. MAIN ST.
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			\$	\$		\$ 68,779	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 68,779	25

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ECM OWNERS COUNCIL
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60646
Phone Number (847) 676-2026
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	\$ 430	\$	4,320	\$ 19	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		4,320	18	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		4,320	37	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		4,320	292	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			4,320		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	5	9,247	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		5	546	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 92,413	\$ 79,839		\$ 10,171	25

Facility Name & ID Number COLUMBUS PARK NRSG REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	SIR Management	X		Working Capital				1,035,000				41,513	6	
7	Insurance Financing											1,488	7	
8													8	
9	TOTAL Facility Related						\$	1,035,000				\$	43,001	9
	B. Non-Facility Related*													
10	See Supplemental Schedule											5,092	10	
11	Interest Income											(588)	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	4,504	14
15	TOTALS (line 9+line14)						\$	1,035,000				\$	47,505	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation from Preferred						\$				\$ 1,185	1
2	Allocation from SIR Mgmt										3,907	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$				\$ 5,092	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

COLUMBUS PARK NRSG REHAB CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0037960

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-17-401-005-0000	Long Term Care Property	\$ 42,927.22	\$ 42,927.22
2. 16-17-401-006-0000	Long Term Care Property	\$ 18,881.69	\$ 18,881.69
3. 16-17-401-026-0000	Long Term Care Property	\$ 86,248.36	\$ 86,248.36
4. SEE ATTACHED	SIR MGMT ALLOCATION	\$ 64,023.09	\$ 5,021.43
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 212,080.36	\$ 153,078.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,685

B. General Construction Type: Exterior Brick

Frame

Number of Stories 6

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		51,845		20	2,592	2,592	24,540	9
10	Various		1993		71,558		20	3,579	3,579	32,213	10
11	Various		1994		46,784		20	2,339	2,339	18,080	11
12	Various		1995		131,277		20	6,662	(6,662)	43,861	12
13	Various		1996		62,128		20	3,108	3,108	18,026	13
14	Various		1997		40,477		20	2,025	2,025	9,264	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		90,694	3,363		3,572	209	23,474	68
69	Financial Statement Depreciation			23,402			(23,402)		69
70	TOTAL (lines 4 thru 69)		\$ 494,763	\$ 26,765		\$ 23,877	\$ (16,212)	\$ 169,458	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 494,763	\$ 26,765		\$ 23,877	\$ (2,888)	\$ 169,458	1
2	ELEVATOR WORK	1998	2,770		20	139	139	533	2
3	ELEVATOR WORK	1998	17,123		20	856	856	3,281	3
4	WALL PAPERING	1998	65,400		20	3,270	3,270	10,628	4
5	TILES	1998	82,368		20	4,118	4,118	14,756	5
6	SHOWER ROOM TILES	1998	35,130		20	1,757	1,757	6,150	6
7	HAND & CRASH RAILS	1998	36,125		20	1,806	1,806	6,321	7
8	BOILER PUMPS	1998	3,736		20	187	187	639	8
9	WINDOW TREATMENTS	1998	30,695		20	1,535	1,535	5,500	9
10	VALANCE/WINDOW	1998	23,077		20	1,154	1,154	4,039	10
11	REMODEL N.STATION	1998	12,670		20	634	634	2,219	11
12	WOLF ROOFING	1998	8,300		20	415	415	1,349	12
13	CARPETING	1998	5,416		20	271	271	912	13
14	WOLF ROOFING	1998	4,000		20	200	200	650	14
15	INSTALL WALL BASE	1998	5,544		20	277	277	900	15
16	HANDRAILS,CRASH RAIL	1998	18,720		20	936	936	3,042	16
17	CARPETING	1998	1,385		20	69	69	224	17
18	WINDOW TREATMENT	1998	4,852		20	243	243	790	18
19	FIRE DAMPERS	1998	32,677		20	1,634	1,634	5,038	19
20	PAINTING & WALLPAPER	1998	14,500		20	725	725	2,235	20
21	BOILER REPAIR	1998	1,291		20	65	65	260	21
22	FANS	1998	1,360		20	68	68	249	22
23	REWIRING & SPEAKERS	1998	1,940		20	97	97	380	23
24	A/C REPAIR	1998	1,532		20	77	77	276	24
25	TUCKPOINT & CAULK	1998	2,250		20	113	113	424	25
26	A/C REPAIR	1998	1,711		20	86	86	301	26
27	FIRE ALARM	1998	1,940		20	97	97	340	27
28	BOILER REPAIR	1998	1,655		20	83	83	270	28
29	STORM BASIN	1998	1,500		20	75	75	231	29
30	PLUMBING WORK	1999	3,573		20	179	179	522	30
31	PAINTING	1999	29,100		20	1,455	1,455	4,123	31
32	WATER CHILLER	1999	2,211		20	111	111	287	32
33	ELEVATOR WORK	1999	58,402		20	2,920	2,920	7,543	33
34	TOTAL (lines 1 thru 33)		\$ 1,007,716	\$ 26,765		\$ 49,529	\$ 22,764	\$ 253,870	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,007,716	\$ 26,765		\$ 49,529	\$ 22,764	\$ 253,870	1
2	AIR COOLED CHILLER	1999	14,147		20	707	707	1,768	2
3	ELEVATOR WORK	1999	2,780		20	139	139	348	3
4	AIR CONDITIONER	1999	77,360		20	3,868	3,868	9,670	4
5	HVAC WORK	1999	8,253		20	413	413	998	5
6	HOT WATER TANK	1999	3,891		20	195	195	520	6
7	SIR REMODELING	1999	12,085		20	604	604	1,359	7
8	HVAC WORK	1999	1,568		20	78	78	176	8
9	HVAC WORK	1999	1,510		20	76	76	171	9
10	BOILER	1999	10,873		20	544	544	1,224	10
11	DOORS	1999	2,376		20	119	119	357	11
12	PIPE AND WIRE	1999	1,395		20	70	70	204	12
13	BLINDS	1999	609		20	20	20	55	13
14	MIRROR OVERLAYS	1999	1,012		20	51	51	136	14
15	RETILE ELEVATORS	1999	4,912		20	246	246	636	15
16	FIRE DAMPERS	1999	956		20	48	48	120	16
17	WALLPAPER ELEVATOR	1999	1,818		20	91	91	228	17
18	ELECTRICAL WIRING	1999	2,470		20	124	124	300	18
19	COMPRESSOR	1999	1,418		20	71	71	166	19
20	TUCKPOINTING	1999	1,350		20	68	68	147	20
21	CHUTE DOORS	2000	2,887		20	144	144	276	21
22	FLOORING	2000	5,190		20	260	260	520	22
23	FLOORING	2000	2,786		20	139	139	278	23
24	BOILER WORK	2000	7,842		20	392	392	490	24
25	BOILER WORK	2000	1,605		20	80	80	133	25
26	GLASS & DOOR	2000	1,525		20	76	76	114	26
27	PAINT	2000	1,095		20	55	55	64	27
28	PAINT	2000	635		20	32	32	35	28
29	HVAC	2000	1,366		20	68	68	102	29
30	HVAC	2000	1,112		20	56	56	65	30
31	SCREENS	2000	1,375		20	69	69	103	31
32	BOILER WORK	2001	4,903		20	184	184	184	32
33	WATER TANK	2001	2,375		20	79	79	79	33
34	TOTAL (lines 1 thru 33)		\$ 1,193,195	\$ 26,765		\$ 58,695	\$ 31,930	\$ 274,896	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,193,195	\$ 26,765		\$ 58,695	\$ 31,930	\$ 274,896	1
2	PAVING	2001	3,700		20	62	62	62	2
3	ROOFING	2001	4,520		20	75	75	75	3
4	LINEN/STORAGE	2001	61,335		20	256	256	256	4
5	PAINT	2001	3,683		20	153	153	153	5
6	WINDOW	2001	830		20	39	39	39	6
7	SINK	2001	866		20	39	39	39	7
8	FLOORING	2001	1,093		20	46	46	46	8
9	WALLCOVER	2001	534		20	23	23	23	9
10	DOOR - PANIC DEVICE	2001	553		20	5	5	5	10
11	HOT WATER TANK	2001	1,378		20	69	69	69	11
12	HOT WATER TANK	2001	2,140		20	62	62	62	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,273,827	\$ 26,765		\$ 59,524	\$ 32,759	\$ 275,725	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1993	\$ 30,241	\$ 960	35	\$ 864	\$ (96)	\$ 7,344	4
5				1993	15,093	479	35	431	(48)	3,665	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Preferred Bookkeeping			1997	18,849	422	20	942	520	4,532	9
10	Allocation from Preferred Bookkeeping			1999	150	29	20	7	(22)	19	10
11	Allocation from Preferred Bookkeeping			2000	945	-	20	47	47	67	11
12											12
13	Allocation from SIR Management			1993	12,988	362	20	655	293	5,774	13
14	Allocation from SIR Management			1994	41		20	4	4	30	14
15	Allocation from SIR Management			1995	297		20	15	15	95	15
16	Allocation from SIR Management			1999	1,411	67	20	71	4	156	16
17	Allocation from SIR Management			2000	852	148	20	43	(105)	72	17
18											18
19	Allocation from SIR Properties - SIR Management			1999	3,832	383	20	192	(191)	479	19
20	Allocation from SIR Properties - SIR Management			1998	1,831	183	20	92	(91)	320	20
21	Allocation from SIR Properties - SIR Management			1997	114	11	20	6	(5)	31	21
22	Allocation from SIR Properties - SIR Management			1994	288	7	20	14	7	108	22
23	Allocation from SIR Properties - SIR Management			1993	490	13	20	25	12	209	23
24											24
25	Allocation from SIR Properties - Preferred Bookkeeping			1999	1,912	191	20	96	(95)	239	25
26	Allocation from SIR Properties - Preferred Bookkeeping			1998	914	91	20	46	(45)	160	26
27	Allocation from SIR Properties - Preferred Bookkeeping			1997	57	6	20	3	(3)	16	27
28	Allocation from SIR Properties - Preferred Bookkeeping			1994	144	4	20	7	3	54	28
29	Allocation from SIR Properties - Preferred Bookkeeping			1993	245	7	20	12	5	104	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.
 See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 90,694	\$ 3,363		\$ 3,572	\$ 209	\$ 23,474	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$330,871	\$37,629	\$32,696	\$(4,933)	10	\$198,187	71
72	Current Year Purchases	15,998	146	1,148	1,002	10	1,148	72
73	Fully Depreciated Assets	17,147				10	17,147	73
74								74
75	TOTALS	\$364,016	\$37,775	\$33,844	\$(3,931)		\$216,482	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,637,843	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$64,540	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$93,368	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$28,828	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$492,207	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Congress Care Center

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 1,064,340			3
4	Additions							4
5	Tower Rental Income				(9,000)			5
6	Telephone Rental Income				(1,602)			6
7	TOTAL				\$ 1,053,738			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,025 Description: Ice Machine \$3075, Copier \$2612, allocation from Preferred \$2071, allocation from SIR \$267

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Preferred		\$	\$ 694	17
18	Allocation from SIR Management			4,972	18
19	Allocation from ECM Owners Council			292	19
20					20
21	TOTAL		\$	\$ 5,958	21

10. Effective dates of current rental agreement:

Beginning 1/1/92

Ending 12/31/01

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 26,847	\$		\$ 26,847	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,186			11,186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			24,749			24,749	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				23,188		23,188	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					2,147	36,566		38,713	13
14	TOTAL			\$		\$ 64,929	\$ 59,754		\$ 124,683	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 81,907	\$	1
2	Cash-Patient Deposits	45,270		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,578,237		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,368		6
7	Other Prepaid Expenses	1,629		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	170,949		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,894,360	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	939,877		15
16	Equipment, at Historical Cost	445,801		16
17	Accumulated Depreciation (book methods)	(501,981)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 883,697	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,778,057	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 166,611	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,361		28
29	Short-Term Notes Payable	1,035,000		29
30	Accrued Salaries Payable	200,936		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)	152,400		32
33	Accrued Interest Payable	1,109		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,800		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	205,033		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,838,156	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,838,156	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 939,901	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,778,057	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,189,116	1
2	Restatements (describe):		2
3	Change in Additional Paid-In Capital	(954,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 235,116	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	704,785	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 704,785	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 939,901	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COLUMBUS PARK NRSG REHAB CTR

0037960

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,560,556	1
2	Discounts and Allowances for all Levels	(133,865)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,426,691	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,277	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 142,277	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,637	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,091	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,221	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,949	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	588	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 588	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	10,672	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,672	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,629,177	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,248,748	31
32	Health Care	2,459,644	32
33	General Administration	1,659,697	33
	B. Capital Expense		
34	Ownership	1,313,360	34
	C. Ancillary Expense		
35	Special Cost Centers	124,683	35
36	Provider Participation Fee	118,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,924,392	40
41	Income before Income Taxes (line 30 minus line 40)**	704,785	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 704,785	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR# 0037960

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,061	2,206	\$ 71,646	\$ 32.48	1
2	Assistant Director of Nursing	1,194	1,227	31,661	25.80	2
3	Registered Nurses	12,224	12,807	251,995	19.68	3
4	Licensed Practical Nurses	28,884	31,111	536,191	17.23	4
5	Nurse Aides & Orderlies	93,501	97,774	790,993	8.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,607	15,306	127,498	8.33	8
9	Activity Director	1,997	2,085	24,272	11.64	9
10	Activity Assistants	10,383	10,833	65,815	6.08	10
11	Social Service Workers	4,402	4,649	62,064	13.35	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,086	32,875	15.76	13
14	Head Cook	4,848	5,353	46,346	8.66	14
15	Cook Helpers/Assistants	17,799	18,779	129,881	6.92	15
16	Dishwashers					16
17	Maintenance Workers	3,839	4,140	38,047	9.19	17
18	Housekeepers	23,325	24,306	163,620	6.73	18
19	Laundry	10,304	11,368	76,045	6.69	19
20	Administrator	1,957	2,086	75,968	36.42	20
21	Assistant Administrator	1,877	2,085	33,932	16.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,798	11,777	115,458	9.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,460	3,808	63,249	16.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	249,401	263,786	\$ 2,737,556 *	\$ 10.38	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 13,800	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	monthly	42,768	10-03	38
39	Pharmacist Consultant	monthly	1,020	10-03	39
40	Physical Therapy Consultant	68	3,413	10a-03	40
41	Occupational Therapy Consultant	50	2,513	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	508	10a-03	43
44	Activity Consultant	91	4,265	11-03	44
45	Social Service Consultant	63	3,137	12-03	45
46	Other(specify)				46
47	Director of Food Services	monthly	22,032	01-03	47
48					48
49	TOTAL (lines 35 - 48)	378	\$ 104,688		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,533	\$ 250,050	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	780	13,677	10-03	52
53	TOTAL (lines 50 - 52)	8,313	\$ 263,727		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount
Martin Lee	Administrator	0	\$ 75,968	Workers' Compensation Insurance		\$ 31,565	IDPH License Fee		\$ 400
Jaime Lloyd	Asst. Admin.	0	33,932	Unemployment Compensation Insurance		32,287	Advertising: Employee Recruitment		15,630
				FICA Taxes		204,220	Health Care Worker Background Check		1,470
				Employee Health Insurance		47,634	(Indicate # of checks performed 210)		
				Employee Meals		28,470	Advertising & Promotion		14,417
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		4,999
				Other Employee Benefits		23,570	Licenses & Fees		5,032
				Union Health & Welfare		97,556	Allocation from ECM Owners Council		12
				Chicago Head Tax		7,151	Allocation from Preferred		84
							Allocation from SIR Mgmt		188
							Less: Public Relations Expense		
							Non-allowable advertising		(7,863)
							Yellow page advertising		(6,554)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 27,815
						\$ 472,453			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
				Description		Line #	Amount		
Description									
Management Fees - see attached									
Management Service Fees - see attached									
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Preferred Bookkeeping	Accounting		\$ 19,750						
Frost Ruttenberg & Rothblatt	Accounting		22,670						
Preferred Bookkeeping	Bookkeeping		72,576						
S.I.R. Management	Dir of Regulatory Services		17,496						
Preferred Bookkeeping	Computer Services		5,184						
Personnel Planners	Unemployment Consult		1,565						
Mid America Programming	Software Fees		1,320						
Kelly Appraisal Consultants	Appraisal		5,000						
Amari and Locallo	Legal - RE Tax		5,258						
Schwartz & Freeman	Legal		10,665						
Michael Best & Friedrich	Legal		14,101						
Stone, McGuire & Benjamin	Legal		10,022						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL		\$			
</									

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	1996	\$ 5,760	3	\$ 1,920	\$ 960	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	1997	13,747	3	4,582	4,582	2,292						
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 19,507		\$ 6,502	\$ 5,542	\$ 2,292	\$	\$	\$	\$	\$	\$

Facility Name & ID Number		COLUMBUS PARK NRSG REHAB CTR		STATE OF ILLINOIS	#	0037960	Report Period Beginning:	01/01/01	Ending:	12/31/01	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>Illinois Council on Long Term Care \$8305</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>10 yrs.</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$		<u>5,903</u>		Line		<u>10</u>	
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES		<u>X</u>		NO			
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES		NO		<u>X</u>		If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$		<u>118,260</u>		This amount is to be recorded on line 42 of Schedule V.			
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>No</u>							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$		<u>28,470</u>		Has any meal income been offset against related costs?			
						<u>No</u>		Indicate the amount. \$			
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>None</u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u>							
	Firm Name:										
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?										
	If no, please explain.										
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										